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In The
Supreme Court of the United States

DAVID KING, *et al.*,

Petitioners,

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF OF *AMICUS CURIAE* AMERICAN THORACIC SOCIETY IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTEREST OF AMICUS 1

SUMMARY OF ARGUMENT 2

ARGUMENT 4

I. Health Coverage Consistently Improves Healthcare Outcomes, as Illustrated by Evidence Related to Respiratory Diseases. ... 4

A. Asthma 6

B. Chronic Obstructive Pulmonary Disease ... 7

C. Sleep Disorders 9

D. Lung Cancer 10

II. Millions of Americans Rely on Subsidies to Buy Health Coverage Through Exchanges Set Up by HHS. 11

III. Congress Did Not Craft a Self-Contradictory, Self-Defeating Statute 13

CONCLUSION 19

TABLE OF AUTHORITIES

CASES

Bell Atlantic Telephone Companies v. F.C.C.,
131 F.3d 1044 (D.C. Cir. 1997) 2

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513 U.S. 115 (1994) 2

Halbig v. Burwell,
758 F.3d 390 (D.C. Cir. 2014) 14

Halbig v. Sebelius,
Civil Action No. 13-623 (PLF), 2014 WL 129023
(D.D.C. Jan. 15, 2014) 18

King v. St. Vincent's Hospital,
502 U.S. 215 (1991) 2

National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566 (2012)..... 3, 14, 15

STATUTES

26 U.S.C. § 36B 3
26 U.S.C. § 36B(b) 3
26 U.S.C. § 36B(c) 3
26 U.S.C. § 5000A 3
42 U.S.C. § 18031(b)..... 3
42 U.S.C. § 18041(b)..... 15
42 U.S.C. § 18041(c) 3, 15
42 U.S.C. § 18071(c) 15
42 U.S.C. § 18091(2)(D) 15
42 U.S.C. § 18091(2)(E)..... 15
42 U.S.C. § 18091(2)(I)..... 15

STATUTES—continued

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 3

LEGISLATIVE HISTORY

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ADMINISTRATIVE MATERIALS

77 Fed. Reg. 30,377 (May 23, 2012) 3
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INTEREST OF AMICUS[1]

The American Thoracic Society ("ATS") is an international educational and scientific organization founded in 1905 that represents more than 15,000 health care professionals. ATS works to prevent and fight respiratory disease around the globe through research, education, patient care, and advocacy. ATS publishes three peer-reviewed scientific journals that disseminate groundbreaking research, including studies on the relationship between access to healthcare and healthcare outcomes.

ATS supports Respondent, the Secretary of the Department of Health and Human Services ("HHS"), because the integrity of nationwide reform of marketplaces for individual health coverage is indispensable for improving healthcare outcomes and reducing the cost of treating Americans who suffer from respiratory diseases.

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[1] The filing of this brief satisfies this Court's Rule 37.2(a) because all parties have lodged blanket written consents with the Court. Pursuant to this Court's Rule 37.6, amicus states that this brief was not authored in whole or in part by counsel for any party and that no person or entity other than amicus or its counsel made a monetary contribution intended to fund the preparation or submission of this brief.

SUMMARY OF ARGUMENT

"[T]he meaning of statutory language, plain or not, depends on context." *Brown v. Gardner*, 513 U.S. 115, 118 (1994) (citing *King v. St. Vincent's Hospital*, 502 U.S. 215, 220–221, n.9 (1991)); *see also Food & Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) ("It is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme. A court must therefore interpret the statute as a symmetrical and coherent regulatory scheme, and fit, if possible, all parts into an harmonious whole.") (internal citations omitted).

This axiom gives rise to another: "The literal language of a provision taken out of context cannot provide conclusive proof of congressional intent, any more than a word can have meaning without context to illuminate its use." *Bell Atl. Tel. Cos. v. F.C.C.*, 131 F.3d 1044, 1047 (D.C. Cir. 1997); *see also Pollard v. E.I. du Pont de Nemours & Co.*, 532 U.S. 843, 852 (2001) ("The term 'compensatory damages . . . for future pecuniary losses' is not defined in the statute, and, out of context, its ordinary meaning could include all payments for monetary losses after the date of judgment. However, we must not analyze one term of § 1981a in isolation.").

The broad context in this case is the Patient Protection and Affordable Care Act ("ACA" or "Act"), Pub. L. No. 111-148, 124 Stat. 119, a law

designed "to increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012) ("*NFIB*"). The more specific context is comprised of those interlocking and mutually reinforcing components of the Act that Congress designed to reform the dysfunctional marketplace for individual health coverage. *See* 42 U.S.C. §§ 18031(b) (requiring states to establish exchanges), 18041(c) (requiring HHS to establish exchanges in states deciding not to do so); 26 U.S.C. §§ 5000A (imposing tax penalty for failure to maintain minimum essential health coverage), 36B(b) & (c) (specifying subsidies for eligible purchasers of coverage through exchanges).

To resolve the issue in this case—namely, whether the IRS's 2012 rulemaking, 77 Fed. Reg. 30,377 (May 23, 2012), *codified at* 26 C.F.R. 1.36B-1(k), 1.36B-2(a), contains a permissible interpretation of 26 U.S.C. § 36B—the Court may not be indifferent to relevant contextual features. Those features are evidenced by the structure of the ACA, by its stated purposes, and by the enormous implications of Congress improbably secreting a time bomb into the ACA's American Health Benefit Exchanges (the "exchanges"), the redesigned marketplaces for individual health coverage. Amicus ATS is chiefly concerned with the third of these, and urges the Court to consider what adopting the absurd reading posited by Petitioners would mean for the health of the millions of Americans who rely for their healthcare on

subsidized health coverage purchased through an exchange. Because Petitioners' reading impermissibly ignores the rules of statutory interpretation and is wholly divorced from the relevant context, Amicus ATS asks this Court to reject it.

ARGUMENT

I. Health Coverage Consistently Improves Healthcare Outcomes, as Illustrated by Evidence Related to Respiratory Diseases.

The causal relationship between health coverage and health outcomes was well-established at the time of the ACA's passage.[2] Amicus ATS can confirm the validity of that general relationship

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[2] *47 Million and Counting: Why the Health Care Marketplace Is Broken, Hearing Before the Sen. Comm. on Finance*, 110th Cong. 2d Sess. 52 (statement of Sen. Charles Grassley, R-Iowa) ("We all know the consequences of not having enough, or any, insurance coverage."); Institute of Medicine, America's Uninsured Crisis: Consequences for Health and Health Care (2009); Jill Bernstein, et al., Mathematica Policy Research, Inc., *Issue Brief No. 1: How Does Insurance Coverage Improve Health Outcomes?* (Apr. 2010) (collecting peer-reviewed studies); *see also* B.D. Sommers, et al., *Changes in mortality after Massachusetts health care reform: a quasi-experimental study*, 160 Annals Internal Med. 585 (2014) (tracing reduction in all-cause mortality to expansion of health coverage); B.D. Sommers, et al., *Mortality and access to care among adults after state Medicaid expansions*, 367 New England J. Med. 1025 (2012) (same).

with regard to the particular diseases on which ATS's physicians and researchers focus their efforts. For the tens of millions of Americans who suffer from lung diseases like asthma,[3] chronic obstructive pulmonary disease,[4] lung cancer,[5] pneumonia, influenza,[6] and cystic fibrosis,[7] from sleep disorders like sleep apnea,[8] or who require critical care to treat life threatening illness or injury, health coverage often substantially

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[3] Centers for Disease Control & Prevention, *Data, Statistics, and Surveillance: Asthma*, http://www.cdc.gov/asthma/asthmadata.htm (last visited Jan. 12, 2015) (reporting 9.3% of U.S. children and 8.0% of adults—over 25 million people in total—have asthma).

[4] T. Tilert, et al., *Estimating the U.S. prevalence of chronic obstructive pulmonary disease using pre- and post-bronchodilator spirometry: the National Health and Nutrition Examination Survey (NHANES) 2007-2010*, 14 Respiratory Research 103 (2013) (estimating that 14% of U.S. adults between ages of 40 and 79 suffer COPD).

[5] *How many people get lung cancer?*, American Cancer Society, http://www.cancer.org/cancer/lungcancer-smallcell/overviewguide/lung-cancer-small-cell-overview-key-statistics (last visited Jan. 15, 2015) (each year, about 220,000 Americans are diagnosed with lung cancer and more than 150,000 die from the disease).

[6] *Seasonal Flu*, Flu.gov, http://www.flu.gov/about_the_flu/seasonal/ (last visited Jan. 15, 2015) ("Each year approximately 5-20% of U.S. residents get the flu and more than 200,000 people are hospitalized for flu-related complications.").

[7] *About CF*, Cystic Fibrosis Foundation, http://www.cff.org/AboutCF/ (last visited Jan. 15, 2015) (CF affects approximately 30,000 Americans).

[8] Naresh M. Punjabi, *The Epidemiology of Adult Obstructive Sleep Apnea*, 5 Proc. Am. Thoracic Soc'y 136 (2008) (noting that estimates of disease prevalence range from 3 to 7%).

determines quality of life and sometimes means the difference between life and death.

A. Asthma

Asthma is "a chronic . lung disease that inflames and narrows the airways" thereby making breathing difficult; it affects 25 million Americans.[9] It generally cannot be cured, but treatment can help those who suffer from it to manage their symptoms.[10] Predictably, there exist significant outcome disparities based on coverage status, both for adults and for children—a reality that was well-known long before the passage of the ACA.[11]

Parents of asthmatic children who lack health coverage must often delay seeking necessary care.[12] Thus it is not surprising that *gaining* health

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[9] *What is Asthma?*, National Institutes of Health, National Heart, Lung, and Blood Institute (Aug. 4, 2014), http://www.nhlbi.nih.gov/health/health-topics/topics/asthma. In extreme cases, asthma can be fatal. *What Are the Signs and Symptoms of Asthma?*, National Institutes of Health, National Heart, Lung, and Blood Institute (Aug. 4, 2014), http://www.nhlbi.nih.gov/health/health-topics/topics/asthma/signs.

[10] *Id.*

[11] *See, e.g.*, J.S. Halterman, et al., *The impact of health insurance gaps on access to care among children with asthma in the United States*, 8 Ambulatory Pediatrics 43 (2008); *see also* T.G. Ferris, et al., *Insurance and quality of care for adults with acute asthma*, 17 J. Gen. Internal Med. 905 (2002).

[12] Halterman, et al., *supra* note 11 (noting that loss of or lack of health coverage makes children more likely go without needed care (1% versus 15% for children without coverage),

coverage has been shown to significantly improve health outcomes for asthmatic children and adults. A 2006 study of new enrollees in New York's State Children's Health Insurance Program (SCHIP) found that children with coverage had fewer asthma attacks and medical visits and half the number of hospitalizations.[13] Likewise, an analysis of records at fifty-seven hospitals found that uninsured adults with acute asthma received poorer quality outpatient care for their asthma prior to presentation at an emergency department, and presented with more severe asthma exacerbations.[14] Lower rates of preventable hospital admissions for asthmatics in Massachusetts (home of the state-level blueprint for the ACA), confirm this connection.[15]

B. Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease ("COPD") refers to chronic bronchitis and emphysema, incurable diseases that make it difficult to exhale all the air from one's lungs, and that cause persistent coughing, shortness of breath,

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lack a personal physician (7% versus 28%), or go without preventative care (16% versus 50%)).

[13] P.G. Szilagyi, et al., *Improved asthma care after enrollment in the State Children's Health Insurance Program in New York*, 117 Pediatrics 486 (2006).

[14] Ferris, et al., *supra* note 11.

[15] Jonathan T. Kolstad & Amanda E. Kowalski, *The impact of health care reform on hospital and preventive care: Evidence from Massachusetts*, 96 J. Pub. Econ. 909 (2012).

and sputum.[16] COPD sufferers are especially susceptible to colds and influenza.[17] Standard COPD treatment regimens involve inhaling one or more vaporized medications; for patients with low blood-oxygen levels, oxygen supplementation is the only treatment associated with improved survival.[18] COPD exacerbations—episodes of acute difficulty breathing and moderate to severe fatigue—are dangerous, and their treatment often requires hospitalization.[19]

Health coverage matters enormously for COPD patients. In a 2005-2006 national survey of more than 4,000 adults diagnosed with COPD, 12% reported having no health coverage and 30% reported having insufficient medication coverage.[20]

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[16] *What Is Chronic Obstructive Pulmonary Disease (COPD)?*, American Thoracic Society, http://www.thoracic.org/clinical/copd-guidelines/for-patients/what-is-chronic-obstructive-pulmonary-disease-copd.php (last visited Jan. 17, 2015).

[17] *Information About COPD*, COPD Clinical Research Network, http://www.copdcrn.org/aboutcopd.htm (last visited Jan. 17, 2015).

[18] P.M. Gold, *The 2007 GOLD [Global Initiative for Chronic Obstructive Lung Disease] Guidelines: a comprehensive care framework*, 54 Respiratory Care 1040 (2009); *see also* Royal College of Physicians (UK), Management of Chronic Obstructive Pulmonary Disease in Adults in Primary and Secondary Care §§ 6, 7 (2010) (describing treatment and citing numerous clinical trials and other studies).

[19] Gold, *supra* note 18; Royal College of Physicians, *supra* note 18, § 8.

[20] R.G. Barr, et al., *Comorbidities, patient knowledge, and disease management in a national sample of patients with COPD*, 122 Am. J. Med. 348, 352 (2009).

Those without coverage used standard health services significantly less—a third reported that their lack of coverage had led them to not fill a prescription for their COPD and 31% reported having gone to the emergency department because of lack of coverage.[21] In addition, of those with insufficient coverage, 34% reported "stretching out" a prescription (i.e., reducing individual doses) and 7% reported sharing another person's medication.[22] Given how clearly coverage affects patients' approaches to their own treatment, it is notable that treating to prevent exacerbations can significantly reduce the health and economic burdens of COPD.[23]

C. Sleep Disorders

More than 18 million Americans suffer from sleep apnea,[24] a disorder characterized by interruptions in breathing during sleep, resulting in chronic daytime fatigue.[25] Without treatment, sleep apnea can increase the risk of a variety of medical problems, including heart failure, stroke,

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[21] *Id.* at 352-53.

[22] *Id.*

[23] Andrew P. Yu, et al., *Incremental third-party costs associated with COPD exacerbations: a retrospective claims analysis*, 14 J. Med. Econ. 315 (2011).

[24] *Sleep Apnea*, The Sleep Foundation, http://sleepfoundation.org/sleep-disorders-problems/sleep-apnea (last visited Jan. 11, 2015).

[25] *What Is Sleep Apnea?*, National Institutes of Health, National Heart, Lung, and Blood Institute, http://www.nhlbi.nih.gov/health/health-topics/topics/sleepapnea (last visited Jan. 20, 2015).

and diabetes;[26] untreated sleep apnea also places others at risk, as the resulting fatigue significantly increases the probability of motor vehicle crashes.[27] Access to health coverage is especially important for patients with sleep apnea due to the complexity of treatment, which typically involves breathing devices, sleep studies, therapy, regular medical consultation, or surgery.[28] However, research predating the ACA indicates that patients without health coverage were far less likely than patients with health coverage to follow up on treatment.[29]

D. Lung Cancer

A 2010 ATS literature review concluded that uninsured patients diagnosed with lung cancer are more likely to die from the disease and that access to screening and care explains the disparity.[30] This makes perfect sense, given the crucial importance of lung cancer screening and preventive care to

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[26] *Id.*

[27] C.F. George, *Sleep apnea, alertness, and motor vehicle crashes*, 176 Am. J. Respiratory & Critical Care Med. 954 (2007).

[28] *Sleep apnea: Treatments and drugs*, Mayo Clinic, http://www.mayoclinic.org/diseases-conditions/sleep-apnea/basics/treatment/con-20020286 (last visited Jan. 20, 2015).

[29] H. Greenberg, et al., *Disparities in obstructive sleep apnea and its management between a minority-serving institution and a voluntary hospital*, 8 Sleep & Breathing 185 (2004).

[30] C.G. Slatore, et al., *An official American Thoracic Society systematic review: insurance status and disparities in lung cancer practices and outcomes*, 182 Am. J. Respiratory & Critical Care Med. 1195 (2010).

outcomes.[31] Indeed, this sort of relationship informed the ACA's requirement for private insurers to cover all "A" and "B" grade preventative services, which now include CT lung cancer screening.[32]

II. Millions of Americans Rely on Subsidies to Buy Health Coverage Through Exchanges Set Up by HHS.

Since passage of the ACA, the percentage of Americans without health coverage has fallen markedly.[33] In the October 2013 to March 2014 enrollment period, over 8 million Americans selected a health coverage plan through an

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[31] D.R. Aberle, et al., *Reduced lung-cancer mortality with low-dose computed tomographic screening*, 365 New England J. Med. 395 (2011).

[32] *Preventive Services Covered by Private Health Plans under the Affordable Care Act*, Henry J. Kaiser Family Foundation, http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/ (last visited Jan. 23, 2015); *Lung Cancer: Screening*, U.S. Preventive Services Task Force, http://www.uspreventiveservicestaskforce.org/uspstf/uspslung.htm (last visited Jan. 23, 2015).

[33] *See* Melissa Majerol, et al., Kaiser Family Found., *The Uninsured: A Primer - Key Facts About Health Insurance and the Uninsured in America* (Dec. 5, 2014) (estimating non-elderly uninsured rate of 18.2% in 2010); Jenna Levy, *In U.S., Uninsured Rate Sinks to 12.9%*, Gallup, http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx (last visited Jan. 10, 2015).

exchange.[34] Of those, about 5.4 million did so through an exchange set up by HHS rather than a state agency.[35] These numbers are expected to grow.[36]

Should this Court adopt Petitioner's reading of the statute at issue and stop the flow of subsidies to Americans who purchase their health coverage through federally established exchanges, a large drop in exchange-based enrollment will follow, which in turn will lead to predictable and preventable adverse health outcomes.[37] Such a result would be contrary to Congress's evident intent.

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[34] *ASPE Issue Brief: Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period* (May 1, 2014).

[35] Amy Burke, et al., *ASPE Research Brief: Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014*, at 3 (June 18, 2014).

[36] Congressional Budget Office and Joint Committee on Taxation, Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act 4 tbl.2 (Apr. 2014) (anticipating that 13 million Americans will purchase coverage through an exchange in 2016, 19 million in 2017, and 25 million in 2018).

[37] *See* Drew Altman, *How 13 Million Americans Could Lose Insurance Subsidies*, Wall St. J., Nov. 19, 2014 (finding for Petitioners in this case "would deny financial assistance for insurance premiums to approximately 13 million Americans in 2016").

III. Congress Did Not Craft a Self-Contradictory, Self-Defeating Statute.

Petitioners' reading of the statute assumes that Congress buried a small cog deep in the ACA's complex and interlocking machinery not in service to the smooth operation of the whole, but as a means of inviting sabotage by states inclined to let HHS establish a health exchange for their citizens rather than doing so themselves. No argument made before this Court has better deserved this answer: "Congress, we have held, does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes." *Whitman v. Am. Trucking Ass'ns, Inc.*, 531 U.S. 457, 468 (2001) (Scalia, J.).

The nature of the problem that exchanges are meant to address—that is, the dysfunction of pre-ACA markets for individual health coverage—and the way Congress designed the exchanges to solve it, highlights the improbability of Petitioners' basic assumption. Others have ably explained that dysfunction.[38] Similarly, others have also explained

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[38] *See, e.g.*, *47 Million and Counting*, *supra* note 2 (statement of Sen. Charles Grassley, R-Iowa) ("Currently the individual market is simply not viable for millions of Americans."); *id.* (statement of Raymond Arth, Chair, Nat'l Small Bus. Ass'n) (describing pre-ACA market price instability, administrative and financial burdens to small businesses, and perennial difficulty for individuals other than the young and healthy of obtaining and retaining useful coverage); *id.* (statement of Prof. Mark Hall) ("the mounting cost of health insurance is driving more and more people out of the market. As the

how the ACA's integrated components sought to address it by establishing exchanges and both requiring and supporting individuals' and insurers' participation in them. *See, e.g.*, *NFIB*, 132 S. Ct. 2614 (Ginsburg, J., concurring in part and dissenting in part) (noting "disastrous" results of various states' pre-ACA attempts at partial, rather than comprehensive, insurance market reform); *id.* at 2674 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting) ("In the absence of federal subsidies to [individual] purchasers [of coverage through an exchange,] insurance companies will have little incentive to sell insurance on the exchanges. . . . That system of incentives collapses if the federal subsidies are invalidated. . . . With fewer buyers and even fewer sellers, the exchanges would not operate as Congress intended and may not operate at all."); *Halbig v. Burwell*, 758 F.3d 390, 410 n.12 (D.C. Cir. 2014) ("We recognize that, from an economic standpoint, such adverse selection risk bodes ill for individual insurance markets."), *rehearing en banc granted, judgment vacated*, No. 14-5018 (Sept. 4, 2014).

Rather than adding another summary of the nature of the problem and Congress's solution to the briefing before this Court, Amicus ATS wishes to emphasize that Congress well understood the impetus for reforming the market for individual coverage and translated that understanding into an

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number of employers offering insurance steadily declines, there has not been any commensurate increase in the number of individuals purchasing their own coverage.").

integrated statutory scheme—one that assumed tax subsidies would flow to any individual who purchases insurance through an exchange, regardless of whether a state or federal agency established that exchange.

Myriad sources reflect Congress's understanding of and intentions for the ACA's reform of the individual health coverage market. To begin, Congress included several relevant statements in the Act itself: it recognized that the economic consequences of "the poorer health and shorter lifespan of the uninsured" are enormous, 42 U.S.C. § 18091(2)(E), that the ACA's provisions would "achieve[] near-universal coverage," *id.* § 18091(2)(D), and, most relevant here, that "[t]he requirement [to purchase coverage] is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold," *id.* § 18091(2)(I). Crucially, Congress also scaled subsidies for exchange consumers based on their income level, *id.* § 18071(c), lest consumers be made to buy something unaffordable to them.

Congress also required HHS to establish exchanges where states do not. *Id.* § 18041(b) & (c). As noted above, it is generally understood that tax subsidies are the lifeblood of an exchange and the insurance marketplace it supports. *NFIB* at 2674 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting). Thus, it is absurd to suggest that Congress mandated that HHS ensure that

exchanges exist nationwide while simultaneously inviting states to turn some or all of those exchanges into useless—but expensive—administrative husks.

Further evidence that Petitioners have wholly misread congressional intent comes from two sources. First, the Congressional Budget Office's December 6, 2012, reply to Congressman Darrell Issa's query as to "CBO's assumption that [subsidies] established by [the ACA] would be available in every state, including states where the insurance exchanges would be established by the federal government." CBO said:

> To the best of our recollection, the possibility that those subsidies would only be available in states that created their own exchanges did not arise during discussions CBO staff had with a wide range of Congressional staff when the legislation was being considered. Nor was the issue raised during consideration of earlier versions of the legislation in 2009 and 2010, when CBO had anticipated, in its analyses, that the credits would be available in every state.[39]

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[39] Letter from Douglas W. Elmendorf, Dir., CBO, to Rep. Darrell E. Issa, Chairman, Comm. on Oversight & Gov't Reform (Dec. 6, 2012), http://www.cbo.gov/sites/default/files/cbofiles/attachments/43752-letterToChairmanIssa.pdf; *see also* Theda Skocpol, *Why Congressional Budget Office Reports Are the Best Evidence of Congressional Intent About*

Second, the states understood that subsidies would flow to exchange consumers regardless of what government set up the exchange. Thus, in response to HHS's question, "Are there considerations for an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange that would be different from the State run Exchanges?" the Texas Department of Insurance and the Texas Health and Human Services Commission gave this answer:

> A state-run Exchange would be modeled to the state's market conditions. In order for a Federal Exchange to be successful, great consideration would have to be given to the variations among state insurance markets, within state insurance markets in a state as large as Texas and to public health coverage programs. Consideration should be given to the direct and indirect impacts of a Federal Exchange on state insurance markets and public health coverage programs to avoid negative outcomes. Form and rate approval, licensure and oversight of

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Health Subsidies 2 (Jan. 2015), http://www.scholarsstrategynetwork.org/sites/default/files/ssn_basic_facts_skocpol_on_cbo_reports_as_evidence_about_health_subsidy_intent_finalfinal.pdf (reviewing all 68 CBO reports drafted in relation to ACA and finding that "no one from either party asked CBO to analyze or project subsidies available to people in some states but not others.").

> financial solvency and enforcement authority of the QHP5 participating in the Federal Exchange should remain with the state.[40]

Evidently, these Texas agencies shared Respondents' understanding that exchange participants' access to federal subsidies was *not* a consideration for a state that opted to rely on a "Federal Exchange" instead of building its own "state-run Exchange."

These examples by no means exhaust the evidence supporting Respondents' arguments. *See, e.g.*, *Halbig v. Sebelius*, Civil Action No. 13-623 (PLF), 2014 WL 129023, *12–18 (D.D.C. Jan. 15, 2014) (examining text and structure of ACA, ACA's stated purpose, and its legislative history). They do, however, cover the waterfront of the types of evidence relevant to a simple question of statutory interpretation, such as the one before this Court.

Congress well understood what Amicus ATS's experience and expertise can confirm: health coverage improves health outcomes, often while also lowering costs. As such, it is inconceivable that Congress would have built an elaborate statutory machinery explicitly for the purpose of making

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[40] Tex. Dep't of Ins. & HHS Comm'n, Public Comments to HHS on the Planning and Establishment of State-Level Exchanges 1 (Oct. 4, 2010), https://www.statereforum.org/sites/default/files/texas.pdf.

health coverage "near-universal," while also inviting states to sabotage that machinery.

CONCLUSION

For the foregoing reasons, Amicus American Thoracic Society urges this Court to protect the health of millions of Americans by affirming the decision below.

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